

Patient Information Sheet

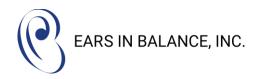
Date:

Name:

Address:	Birthdate:
City: State: Zip:	Phone:
Email Address:	-
Emergency Contact:	Phone:
Primary Care Physician:	Phone:
Referring Physician:	_Phone:
By signing below, I acknowledge that a copy of the offices of Privacy Pra	
I hereby authorize and direct all payments to Ears in Balance, Inc, for the if any, otherwise payable to me under the terms of my insurance. I hereby release any information acquired during my treatment to my insurance of physician. I hereby authorize photocopies of this form to be valid as the disgning this I am responsible to check if Ears in Balance, Inc is in network provider. I also understand if Ears in Balance, Inc is not a participating presponsible for the charges of my treatment.	y authorize Ears in Balance, Inc to company and to the primary care original. I acknowledge that by with my insurance and participating
Patient Signature:	

10501 Telegraph, Suite 100 Taylor MI 48180 & 18451 West Twelve Mile Rd. Suite 201 Lathrup Village, MI 48076

Telephone: (248) 900 EARS (3277)
Email: information@earsinbalance.org



NAME:	DATE:	

THE HEARING HANDICAP SCREENING FORM

INSTRUCTIONS: The purpose of this scale is to identify the problems your hearing loss might cause you. Please select YES, SOMETIMES, or NO for each question. Do not skip a question if you avoid a situation because of your problem. If you currently wear hearing aids, answer the question the way you hear without a hearing aid.

Does a hearing problem cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel frustrated when talking with members of your family?	YES	SOMETIMES	NO
Do you have difficulty when someone speaks in a whisper?	YES	SOMETIMES	NO
Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when listening to TV or the radio?	YES	SOMETIMES	NO
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO



Medical Records Release Form

To:	
Patient Name:	
DOB:/	
The above patient has come to our office of please fax or email all of their following in Past / Present Audiogram Clinic Notes Medical Clearance	for their hearing aid needs. At the patients request, formation at your earliest convenience:
I hereby grant the above named person(s) / medi requested information from my medical records.	
Expiration Date:	
(Patient may revoke this d	ocument verbally or in writing at any time)
Signature (Last Name, First Name)	 Date
Print (Last Name, First Name)	

Phone: 248.900.3277



EARS IN BALANCE, INC

day's I	Date:
tient N	fame:DOB:
	Please write a short response or circle applicable answers
•	What brought you here today?
•	Have you noticed problems with your hearing? YES / NO
	What problems have you had?
•	How long have you had them?
•	When was your last hearing test?
	Where?
	Can you bring us a copy for our records? YES / NO (If No) Why not?

- Do you have problems hearing in one ear or both ears? One (Left/Right) or Both
- Did your hearing loss happen all of a sudden? YES / NO. Has it gotten worse over time? YES / NO
- Do you have ringing in your ears? YES / NO
- Have you had a lot of <u>ear infections</u>? YES / NO
- Do you have any pain in your ears? YES / NO
- Have you had any drainage from your ears? YES / NO

•	Do you ever feel dizzy? YES / NO Have other people in your family had hearing loss? YES / NO Do they complain that you need to have your hearing checked? YES / NO Why?		
	it ha ES / N	rder for you to hear women's voices? YES / NO Men's voices? YES / NO Children's voices?	
•	Has	anyone ever told you that your television is too loud? YES / NO	
•	Has	anyone ever told you that you speak too loudly? YES / NO	
•	Do y	you have to ask people to repeat what they said a lot? YES / NO	
•	Do y	you hear people speaking but can't understand what they are saying? YES / NO	
•	Hav Do y	re you worked in places that are very loud and noisy? YES / NO re you served in the military? YES / NO you shoot guns or do other loud activities? YES / NO you play music loudly? YES / NO	
•	in la	there times when you have more trouble hearing, such as in a car, restaurant, or theater, or arge groups? YES / NO medications	
•			
	0	1For	
	0	For	
	0	3For	
	0	4For	
	0	5For	
	0	6For	
	0	7For	
	0	8For	
	0	9For	
	0	10For	



Patient Name:				
DOB:/				
I hereby grant Ears In Balance permission to text and matters relating to the appointment to my ce	me communications like Appointment Reminders Il phone.			
Cell Phone Number:				
Expiration Date:				
(Patient may revoke this de	ocument verbally or in writing at any time)			
Signature of patient/Guardian	Date			
Print (Last Name, First Name)				
I do not want Ears in Balance to text	my information to my cell phone			
Signature of Patient/Guardian	Date			
Print (Last Name, First Name)				

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25426 Goddard Rd, Taylor, MI 48180

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